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Shifting the management model of Brazilian health services: perceptions of major stakeholders on the participation of the private sector in public hospital administration

Bárbara Bulhões [b], Hugo Bellas [a], Rodrigo Arcuri [d], Paulo Victor Rodrigues de Carvalho [c], Alessandro Jatobá [a,*]

[a] Centro de Estudos Estratégicos Antônio Ivo de Carvalho (CEE) - Fundação Oswaldo Cruz ,Rio de Janeiro, Brazil
[b] Instituto de Medicina Social Hesio Cordeiro (IMS) - Universidade do Estado Rio de Janeiro (UERJ) -, Rio de Janeiro, Brazil
[c] Instituto de Engenharia Nuclear (IEN) -, Rio de Janeiro, Brazil
[d] Universidade Federal Fluminense (UFF) -, Rio de Janeiro, Brazil

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ABSTRACT

In Brazil, public hospitals are managed according to several different models. The participation of private or third-sector organizations has been growing in a significant manner, especially in the past decade. The present study explores the perception of public administrators and health councilors on the main aspects of outsourcing the management of public health services to the private sector. The study shows that the main disadvantages are related to the reduction of the State's role as regulator, making it more difficult to size services up according to the demands of the population. Among the main advantages pointed out are contributions to reduce bureaucracy in the administration and more freedom for the management of physical, financial, and human resources. The present study contributes to transcend the political-ideological discussion on private sector participation in the management of public and universal constitutionally guaranteed services, presenting the point of view of administrators in Brazil, not very explored in recent literature.

1. Introduction

Hospital administration is a highly relevant subject to ensure integrated and high-quality assistance to the population's health. In capitalist nations in which universal health systems exist, such as Brazil, Canada, France, and the United Kingdom, especially in those in which liberal economic policies prevail, this discussion includes understanding how to build models that incorporate private-sector participation in the management of public resources.

In the case of Brazil, this discussion first reverberated after the plan for the reform of the state bureaucracy proposed by Bresser-Pereira, tied to the idea of a minimal state [1]. As a result, the introduction of private- or third-sector organizations in the management of the country's healthcare increased significantly, especially during the last decade, when similar models were adopted to those used by countries such as Canada, Spain, England, and France [2–5].

The private participation in health management in Brazil is mainly expressed by the so-called social healthcare organizations (SHOs). Moreover, it is noteworthy that SHOs are hired to manage public health units, like hospitals and primary care clinics, but these units remain publicly held. This means that public resources once employed by governments to manage health services themselves are now transferred to private- or third-sector organizations that deliver public health services [6,7].

Although the shift to the private sector and the consequent transformation of the state's role as a regulator has been widely explored in the literature, much of the discussion focuses on the political-ideological aspect. However, the perceptions of administrators and health councilors have been little explored by academia. Even then, models based on the sharing of healthcare network management between private and government-run organizations are advancing in Brazil and worldwide, and a deeper discussion on the subject is necessary.

In this context, the present study attempted to analyze Brazilian administrators and health councilors' perceptions of the actuation of privately run organizations in the management of medium and large hospitals.

2. Methods

This is an exploratory study, underpinned by grounded theory [8,9], whose data collection procedures are based on telephone and/or online semi-structured interviews. The investigation is guided by the question: according to local administrators and representatives of society, what are the

* Corresponding author.
E-mail addresses: barbara.andrade@fiocruz.br (B. Bulhões), hugo.bellas@fiocruz.br (H. Bellas), rodrigoarcuri@id.uff.br (R. Arcuri), paulov@ien.gov.br (P.V.R. de Carvalho), alessandro.jatoba@fiocruz.br (A. Jatobá).

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advantages and disadvantages of private sector participation in large and medium-sized hospital management?

Participants' contact information was obtained from public open-data sources and from the websites of the local health departments and councils. To the date on which the study was carried out, 456 Brazilian municipalities had medium-sized or large hospitals, distributed in all Brazilian regions, for a total of 798 hospitals. Of these, 80 municipalities had specific regulations for the SHO management model and were therefore selected for the study. All municipalities were contacted by phone and invited to participate in the study between November 2019 and March 2020. The emergence of the COVID-19 pandemic in Brazil during that period determined the choice of procedures for data collection, which was necessarily done via phone calls or online.

Overall, 38 municipal health secretaries and 55 presidents of municipal councils agreed to participate. The municipal health secretaries who completed their participation came from 16 cities that have specific legislation to regulate the situation of SHOs. Among the municipal health councils, 18 cities have this kind of legislation.

The interview had eight questions, six of which were closed-ended and two of which were open-ended. The interviewers were two members of the research team with backgrounds in public health, and equally experienced in the data collection procedures. The objective questions followed a 5-point Likert-type scale, where 1 means "I disagree completely" and 5 means "I agree completely." Open-ended questions gave participants the possibility to describe what they considered to be the advantages and disadvantages of the SHO management model.

Participants were approached by phone and invited to be interviewed live for approximately 20 minutes. The ones who claimed they could not participate live were given the option to receive the interview via email. Although initially intended to be recorded and transcribed verbatim, none of the first 10 live participants authorized the recordings. Thus, the research team decided not to record any more live interviews, and the responses were transcribed in field notes.

The investigation was pretested with a random sample of municipal health secretaries and councilors of municipalities in the state of Rio de Janeiro, Brazil. Twenty cities were selected for the pretest, which obtained five responses. No significant changes in the data collection procedures resulted from pretesting.

As for the data analysis procedures, the closed-ended questions had their frequencies grouped and analyzed comparatively, while open-ended questions were submitted to thematic content analysis **[10]**. The organization of the material included the pre-analysis of the content by means of the overall reading of the results to comprehend the general content, define the answers collected for analysis, and reject participations that were considered invalid.

Coding consisted of the exploration of the organized material, the separation and enumeration of the content for comprehension of sense and relevance. The analysis of the open-ended questions begins with the construction of word clouds **[11–13]**. We highlighted the terms that were more relevant for the analysis of the responses' content and removed the words that repeated the content of the questions.

3. Results

3.1. Analysis of Closed-ended Questions

The analysis of the closed-ended questions was organized in themes, as described in the following sub-sections.

3.1.1. Compatibility and quality of services

The first statement, "*The services provided by the SHOs are compatible with the needs of the healthcare network in my municipality/state,*" presented 37% of the secretaries agreeing with the statement. Among the councilors, responses were balanced, with a significant number of responses from both those who agreed and those who disagreed, as well as from those who placed themselves in an intermediary position.

For the second question, almost half the secretaries agreed that "*The problem-solving capacity of the SHO management model is compatible with the needs of the population in my municipality/state.*" Less than half the councilors disagreed with the statement. Therefore, regarding the compliance of secretaries and councilors on the problem-solving capacity of the model being compatible with management needs, we observed a higher cohesion among secretaries.

Meanwhile, "*The quality of the services provided by the SHO management model is incompatible with the needs of the population in my municipality/state*" yielded disagreement from most of the secretaries interviewed and half the councilors. We therefore understand that the participants in the survey tended to find compatibility between the model and the quality of the services provided according to the local health-related demands.

3.1.2. Costs and coverage of services

"*The cost/benefit ratio of the SHO management model in my town/state is compatible with the results of the services provided*" yielded most answers agreeing with this affirmative among health secretaries. For the councilors, this relation does not have a cohesive opinion, with a bit less than half of the responses disagreeing with the statement, while the other half was divided between intermediary and agreement.

The last closed question of the questionnaire states that "*Adopting the SHO model reduces access to services in my town/state.*" Most of the secretaries and councilors who answered this question disagreed with the statement. Therefore, most of both groups of interviewed subjects stated that there was no relation between adopting the SHO model and reducing access to services.

For most secretaries, the SHO model solves problems and provides quality, a good cost/benefit ratio, and services that are compatible with the demands of the healthcare network of the municipality/state. In addition, the model does not reduce users' access to municipally and state-run services. Among councilors, opinions were not homogeneous; there was more of a balance between those who agreed and those who disagreed with the statements. Only the question regarding access yielded expressive cohesion of the opinion of participating councilors, noting that this model does not reduce users' access to health services in their municipality/state. Table 1 summarizes the frequencies of responses to closed-ended questions.

3.2. Analysis of Open-ended Questions

The initial analysis of these answers via word cloud shows us the emphasis of secretaries' opinions on the advantages regarding elements that qualify the services provided by the SHO, with the words "agility," "economicity," and "flexibility," as shown in Figure 1.

Most participants listed only the advantages of the SHO model (29 answers), and only three responses did not identify any benefits, while four did not clearly identify advantages or disadvantages. The latter point to the fact that this administration model complements the services provided by the Unified Health System (SUS) and criticize the irresponsibility of government management: "*In the event of responsible management, it would be great,*" says one of the answers.

The elements related to the advantages of the SHO management model are mostly related to the so-called "de-bureaucratization" of the administration. This issue, according to those interviewed, contributes to agility and economicity in the purchase of materials and consumables, the flexible management of human resources, administration based on production goals, and an evaluation of results focused on efficient management, with more autonomy for decision-making.

The flexibility to make contracts appears, in the opinion of municipal health secretaries, as a contribution to the "amplification of the services offered" and to "help provide the population with services not usually available and/or excessively demanded in the primary healthcare network."

Human resources management is the subject of most of the responses, mentioning issues such as agility to replace professionals that do not adapt to their jobs, hiring specific professionals according to the demands

Table 1
Frequencies of responses to the closed-ended questions.

Questions	Completely disagree		Disagree		Neutral		Agree		Completely agree		Total	%
	n	%	n	%	n	%	n	%	n	%		
Municipal Health Secretaries												
The services provided by the SHO are compatible with the needs of the healthcare network in my municipality/state	6	16%	1	3%	7	18%	10	26%	14	37%	**38**	**100%**
The problem-solving capacity of the SHO management model is compatible with the needs of the population in my municipality/state	6	16%	0	0%	10	26%	10	26%	12	32%	**38**	**100%**
The quality of the services provided by the SHO management model is incompatible with the needs of the population in my municipality/state	21	55%	7	18%	4	11%	1	3%	5	13%	**38**	**100%**
The cost/benefit ratio of the SHO management model in my town/state is compatible with the results of the services provided	6	16%	3	8%	5	13%	13	34%	11	29%	**38**	**100%**
Adopting the SHO model reduces access to services in my town/state	21	55%	5	13%	6	16%	3	8%	3	8%	**38**	**100%**
Municipal Health Councils												
The services provided by the SHO are compatible with the needs of the healthcare network in my municipality/state	21	55%	4	13%	9	16%	8	8%	13	8%	**55**	**100%**
The problem-solving capacity of the SHO management model is compatible with the needs of the population in my municipality/state	21	55%	1	13%	10	16%	9	8%	12	8%	**55**	**100%**
The quality of the services provided by the SHO management model is incompatible with the needs of the population in my municipality/state	25	55%	2	13%	10	16%	4	8%	14	8%	**55**	**100%**
The cost/benefit ratio of the SHO management model in my town/state is compatible with the results of the services provided	20	55%	5	13%	11	16%	7	8%	12	8%	**55**	**100%**
Adopting the SHO model reduces access to services in my town/state	28	55%	7	13%	6	16%	3	8%	11	8%	**55**	**100%**

of the municipality, the fact that it is easier to hire physicians, in particular specialists, and better performance of the workforce.

Another issue that draws attention in the responses is the relationship between this administration model, the health policies of secretaries, and the demands of the municipal healthcare network. Among the health secretaries that answered the question, one stated that this administration model "*Allows for more agile management and a response time that corresponds to the needs of the health network*." Another participant of the survey agreed: "*In my opinion, this administration model facilitates gains in scale and in scope, because when two or more institutions get together to manage a hospital network, it makes providing service and the resolution of different issues easier*."

As for the disadvantages of the SHO model, the words that had more weight in the responses of municipal health secretaries that participated in the survey were "control," "indicators," "goals," and "health."

Two participants answered the question without providing a clear direction for their position: "*To answer this question, it is necessary to reflect that its origin occurs in the ensemble of the Administrative Reform, whose basic premise was the de-bureaucratization of the Brazilian State*" and "*Management of services is not direct, it is done by following goals and indicators*."

There were also six answers that indicating no disadvantages to the SHO management model. These answers range from "*no disadvantage*" to "*Managers' resistance to the format of the administration model*" and "*the disadvantage would be to face an SHO that is bad at managing, but we carried out a very strict selection process and expected demanding results that varied in the payment of performance*."

One of the answers links the state's role as inspector and controller: "*Making external control agencies understand that it is the municipality that defines the goals, the indicators, and the health policies according to their needs and the directives defined by the Ministry of Health*." This answer mentions the importance of studies that analyze administrators' opinions on the state's role as a regulator and political aspects of the relationships between the governments and the SHOs.

The elements that were found in the answers provided by the municipal secretaries of health who indicated the disadvantages of the SHO management model reveal issues related to conflicts of interest between government institutions and officials and private interests. Also mentioned were problems in the writing of management contracts, high costs, privatization of healthcare services, precariousness of work, lack of transparency, "*absence of a binding relationship with the municipality*," "*lack of monitoring and evaluation of contracts*" by government agencies, "*lack of quality of the services offered*," and "*lack of knowledge of local realities*" by the SHO. One of the answers that did not include a direct disadvantage identified acceptance of social control as a possible issue. The responder presented as a solution "*the establishment of criteria to classify good organizations*."

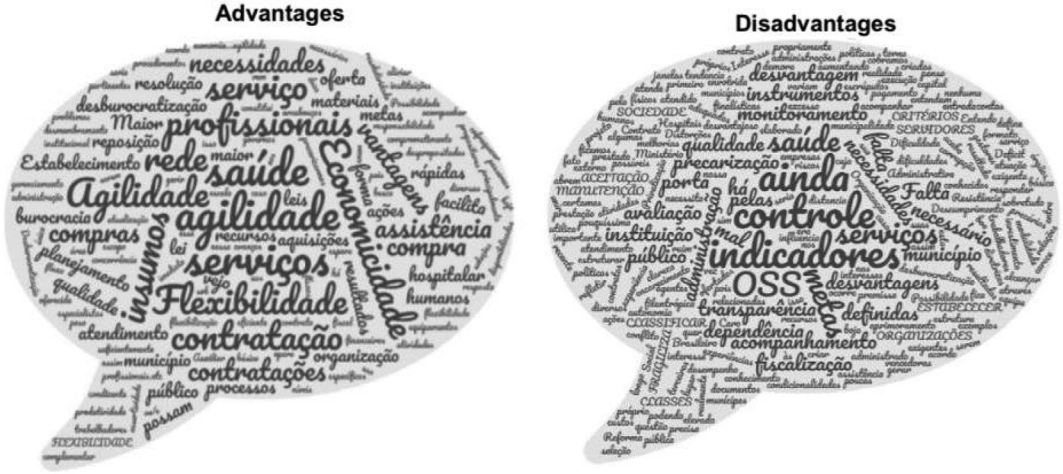

Figure 1. Word clouds related to the advantages and disadvantages of the SHO model according to municipal health secretaries.

The analysis of the secretaries' opinions on the advantages and disadvantages of the SHO model indicates the urgency of new studies on the relationship between municipal health secretaries and SHOs. One should note that the elements presented in both answers are conflicting.

As for the answers of municipal health councilors, the initial word cloud analysis highlights the following terms related to the advantages of the SHO model: "service(s)," "none," "municipality," "advantages," "primary," "population," and "health," as shown in Figure 2.

They express the role of those who were interviewed as social controls, and they list the needs of the town's population. Answering about the advantages of the model, the councilors' responses showed disadvantages in 26 cases; 23 showed benefits, while three said this relation depends on an evaluation of the administration model in each town. The unfavorable elements are late salaries, embezzlement of public resources, transparency of information, "seriousness" of the SHO, outsourcing of services, fraud and scandals, outsourcing of responsibilities, precariousness, and political sponsorship.

As for the advantages, they would be flexibility in human resource management (agility in the replacement of professionals and night-shift working hours), economicity, transparency, more agile management (contracts, purchases, response to users), reduction in state expenses, amplification of access to medical and nursing assistance, humanized and qualified service, administrative reference, "*more productivity at a lower cost*," experience in the management of medium- and high-complexity services, and "*inspection process is more effective and easier*."

The quality of the service is a favorable and unfavorable element regarding the advantages of the SHO model. The survey also received answers that show advantages but problematize them, such as *"Ease of personnel management, but it can simply undo relations and weaken the team's qualification, in addition to resulting in a higher cost to the state*."

Among the main words mentioned in the councilors' answers on the disadvantages of the SHO management model (Figure 2) are "service(s)," "SUS", "management," "municipality," "services," "professionals," "public," "quality," "network," "control," and "precariousness." They reinforce the indication of the council's role as inspectors and social control enforcers and state that issues such as human resources, the quality of service, and the precariousness of the SUS healthcare networks are concerns regarding the SHO model.

Most of the councilors' responses indicate the disadvantages of the SHO model (38 answers). Those that described problems or other situations not directly related to advantages or disadvantages (7 answers) showed, as mentioned in one of the answers, that "*the large number of companies offering services and the public call system favor hiring of whoever demands a lower payment, and not the most competent person for the job*." In this sense, another answer says that "*I believe the SHOs were extinguished in the municipality. But as usual, we are awaiting the responses registered by members of the Inspection Commission and by the financial commissions*." These opinions criticize the lack of transparency and poor inspection by the state.

The responses that include disadvantages have more written content and more textual and conceptual elements than the other answers (including those of secretaries of health). Among the answers are elaborate arguments with data and experiences, both local and from other territories, as can be seen below:

Although this administration model is not employed in my municipality, the information acquired at events that took place in other towns is enough for an evaluation. This model ended up in the formation of gangs that specialize in fraud. The case of the state of Rio de Janeiro exemplifies this thesis very well. Chaos was implanted in the health sector during the mandates of former [name] governments, as can be seen in the report of the Federal Public Ministry for the [name] operation. I believe these questions are irrelevant, given that we are aware of the frauds that occurred. I respond in my thesis for my municipality, where this model was not implemented in spite of an attempt by an SHO that was later blown in [state] during the [name] Operation.

Studies have shown that the SHO model has been expensive and disappointing in terms of quantity and quality of services provided. In my municipality, the outsourced Children's Hospital recorded an astounding increase in the number of infant deaths in the first months of the new management, when the entire staff was replaced by professionals without any experience in the area. Other problems were observed in the state, such as the closing of emergency units.

The great disadvantage is the fragmentation of the SUS network and the bottlenecking of healthcare. Thinking in terms of inter-sector and complex strategic actions is one of the great assets of the SUS. Actually, when we look at the data, we see that the higher number of claims against the SUS refer to secondary healthcare and medical specialties, especially those related to health insurance. Throughout the country, we see that the government network is the veritable powerhouse of the SUS, and it is actually cheaper and more efficient than the private health sector; see the outbreak of dengue fever in [state] in 2019, when the private sector threw its patients over to Basic Health Units, and even then they managed to accumulate 12 hours of waiting time, and the health expenses of those who pay for health insurance are higher than what the government spends per person, and the SUS covers many more procedures than any private health insurance plan. These figures are more than enough to convince me that adopting private logic is not efficient, nor does it contemplate Law No. 8080, which places the SUS as an institution with the duty of actually providing the right to healthcare to all those in Brazilian territory.

Some councilors' intense dissatisfaction regarding the subject was clear when they declared that the disadvantages were "all possible disadvantages," "profiting from disease," "precariousness of government services!", "overbilling," and "meddling."

In general, these opinions mention as disadvantages "*the fragility of job relations*," "*precariousness of the workforce*," "*the fragility of the relationship with the community*," the "*reduction of access to social control*,"

Figure 2. Word clouds related to the advantages and disadvantages of the SHO model according to municipal health councilors.

"*embezzlement*," "*low salaries*," "*difficulty demanding changes when the service does not provide quality service*," when "*managers evade responsibility*," and when "*the summoning of public officers is reduced*."

In these answers, elements related to human resources deepen the discussion on issues such as moral harassment at work due to political influence and include the lack of criteria for hiring personnel. Even the consequence of these questions is described, showing that "*the increase in medical errors [is] related to exhaustion and work overload*."

Another relevant factor refers to the matter of access to health services. Some councilors' answers mention that SHO management "*does not follow the SUS policies and guidelines, dictate their own rules on the functioning of the service, [and] most of them infringe the users' right*." This suggests that the SHO pursued only its own interest and not that of the municipal health secretary, according to another municipal health councilor.

These disadvantages further worsen privatization, outsourcing, and "*outsourcing of the services provided at a very high cost*," concepts that are only observed in councilors' answers and that conceptually deepen the issues referring to relations between municipalities, SHOs and service providers, and suppliers of materials and consumables. There are also three answers that state there are no disadvantages and even elaborate that there is an "*amplification of the offer of services, sending over a minimum number of patients to larger cities*."

3.3. Intermediary Analysis Categories

Considering the elements found in the answers, the study elaborated intermediary categories of analysis for the responses of the groups of participants. These categories are defined according to the subjectivities of the group of researchers who analyzed the answers. These were created and named according to the codified data of the narratives of those interviewed within the initial categories related to the concepts that guided the survey.

For this purpose, the study chose the following guiding concepts: public management, state reform, management of human resources, regulation, inspection and social control, healthcare networks, administrative integrity, productive restructuring, job precariousness, and right to healthcare. These are mainly related to the state's role as a regulator in public health management on a local basis.

Considering the purposes of use of the systematized registration units, the present study comprehends as registration units the groups of health secretaries and municipal health councils that participated in the study. In this manner, the research groups represent subject registration units that will be called Institutional Management Discourse (referring to the opinion of health secretaries) and Institutional Social Control Discourse (referring to the opinion of health councils).

In brief, the content analysis provides the construction of a schematic table (Table 2) of the relations between the subject registration unit and the issue registration units in the elementary context units (advantages of the SHO management model, disadvantages of the SHO management model, praxis analysis) and in the context units (cutoff of the interviews related to the characters, subjects, and elementary context under analysis).

This association of contents builds categories that facilitate the expression of the semantics of participants' opinions. In this manner, the context units show the participants' preoccupation with describing the scenarios and developing arguments to contribute to the increasingly complex issue of SHOs.

4. Discussion

The interviews aimed to assess the perceptions of municipal health secretaries and councilors who have, under their jurisdiction, medium and large hospitals run by the municipal or state government but managed by private- or third-sector organizations. This redefinition of the role of the state foments the evasion of responsibility by the state when it comes to developing goods and services, suggesting a role for the state that is restricted to regulation [2,14].

This policy fomented the strengthening of the managerial principle of "the third sector," defined as a private, non-governmental, non-profit organization that is self-governed and is voluntarily associated. However, this segmentation presents controversies, as SHOs are supposedly non-governmental, autonomous, and non-profit in nature, although their projects and their scope are strongly supported by governmental policies—thus, they are not as autonomous as intended [15,16].

The controversy also appears mainly when embezzlement and exchange of influences are reported. On the other hand, the possibility of paying high salaries to employees causes tension in the budget and in the management of specialized human resources for hospital care.

In this manner, this reform collaborated with the current understanding of SHOs as components of the subsystem of services of the Brazilian Health Economic-Industrial Complex [17,18] that generates and propagates technologies, promoting social institutional dynamics, state structuring, and its relation with the private sector.

In addition, the sample cutoff of the present study for medium and large hospitals reinforces the magnitude and the importance of understanding the opinions of local decision-makers in terms of compliance and regulation of the SHO model, as well as for the inspection and revindication of rights [19].

According to Reis and Coelho [20], the expansion of SHOs in Brazilian territories over time has become more relevant considering the crisis in the sector due to the lack of efficient, modern, and humane management, with high costs and poor results. This issue deepens the de-responsibilization of direct execution of administrative activities in the hospital sector and the value given to non-governmental public spaces. For the authors, the advancement of this administration model is part of an international process of restructuring capital by means of sector reforms triggered by cultural relations of the New Public Management [21].

Therefore, hybrid models contribute to changing cultural aspects of performance in health services, further worsening government–private dichotomies at the micro-political level of healthcare production and collaborating for the privatization of the idea of public interest and democracy.

The expansion of this model has been occurring since 1995 in countries with loans taken from international financial institutions as well as in those with well-consolidated social welfare systems, where companies profit from offering healthcare services, protecting the market. In Latin America, this fact causes great social impact, which translates into an increase in income inequality.

In Brazil, beginning in the 1970s, issues related to state reform and social security resumed with the fight for the country's re-democratization and for the citizens' rights in an effort to build public social policies for a social welfare state. Along with this, at the time, the active Brazilian sanitary movement rejected the health system in force, which was fragmented, deepened inequalities, privileged actions of medicalization and privatization, and looked down on public health and social issues [22–25].

Currently, the change of these perspectives on the formulation of public policies, together with the instability of Brazilian democracy, worsened by the COVID-19 pandemic, has made it urgent to comprehend and map who and how articulate the strategic players are for the organization of medium and large hospitals, given the diversity of Brazil and how geographic, social, and economic disparities affect the access to health services [26–28].

The first challenge to be addressed is the possibility of dialogue with decision-makers. One of the hypotheses for the refusal to participate in the survey is related to the difficulty of talking about the subject in the public arena and debating its characteristics and complexities. The difficulty of exchanging ideas, experiences, and knowledge on the subject affects scientific production and even the advancement of a stricter regulation toward more transparency of the SHO model.

The findings of this survey converge around the need to structure and elaborate suitable inspection tools. Similarly, they also show relative consensus: there is little transparency in the processes adopted by SHOs. We therefore recommend, for the purpose of identifying advantageous and disadvantageous elements, that it is necessary to extrapolate the discourses to the social praxis in the territory, as mentioned in an answer that referred to

Table 2
Summary of the content analysis of the open-ended answers.

Registration Unit Character	Subject Registration Unit	Elementary Context Unit	Context Unit
Institutional Management Discourse	Public administration in the SUS	Qualification of the advantages of the SHO management model	"The building of an organic institutional model for the government sector in the municipality, sufficiently flexible to allow for the planning of actions based on well-defined government policies where it is possible to predict the result of the service to be offered to users, is a tireless quest of governments at all levels."
	SHO inspection and regulation	Qualification of the disadvantages of the SHO management model	"This model becomes disadvantageous when the Management Contract is poorly elaborated, with ill-defined goals, and when the project does not clearly state the desired result, as well as in the cases in which inspection is below what is necessary for the proper follow-up of the execution. It is important to structure a good team and adequate inspection tools."
			"Acceptance by civil society and classes, establishment of criteria to classify good organizations"
	Access to the right to health	Praxis analysis	"Helping provide the population with services that are not available and/or are much demanded in the primary healthcare network"
			"Poor knowledge of local realities, personal interests"
Institutional Social Control Discourse	Public administration in the SUS	Qualification of the disadvantages of the SHO management model	"Management control requires the implementation and training of inspectors and administrators"
	SHO inspection and regulation	Qualification of the disadvantages of the SHO management model	"The lack of government management is very large, there is no responsible follow-up; as for complying with the agreement, there are suspected overbillings in purchases and corruption in the transfer of funds, especially directing benefits from government partners to private partners; we councilors are denied access to documents, competition letters between the public government."
		Qualification of the disadvantages of the SHO management model	"Lack of transparency of the processes."
		Qualification of the advantages of the SHO management model	"The process of inspection by Social Control is more effective and easier to carry out, with the immediate possibility of closing an eye when necessary. In addition, we also know that any service-providing model can work, depending exclusively on everyday inspection by Social Control."
	Guarantee of access to healthcare	Praxis analysis	"The advantage that the population has easy access to public healthcare."
			"They restrict users' access to the service, they do not follow the SUS policies and guidelines, they dictate their own rules on the operation of the service, most of them harm the rights of users, it is difficult to control accountability, it is hard to control health indicators. As for the 'goals,' they do not carry out public bidding, they reduce the number of professionals in final and intermediate areas such as nursing and cleaning teams, with demand that is higher than the capacity of service provision, precariousness of work relations, turnover, increased medical errors due to exhaustion and work overload."
	Political instability	Qualification of the disadvantages of the SHO management model	"The SHO management model speaks for itself. Many frauds and scandals, shown by the different operations in which these organizations were active, such as in the *FRATURA EXPOSTA* OPERATION, *ASSEPSIA* OPERATION, and many others. In my opinion, these lessons learned are enough to abolish the model."
			"Excessive political influence hampers this management model"
	Precariousness of access to healthcare	Qualification of the disadvantages of the SHO management model	"Increase in government expenses with this kind of outsourcing; weakening of workforce quality, reduction of inspection of the services provided; reduction of access to social control; the precariousness of labor with an impact on productivity; risk of persecution."

"*lack of knowledge of the local reality*, [and pursuing] *their* [SHOs'] *own interests*."

Keeping in mind the appropriation of praxis by these actors in their territory and the possibility of building public arenas of debate on the experiences of this administration model, we can observe the need to move on to strategic actions that foment permanent education under the management, inspection, and regulation of the SHOs. The opportunity to create an institutional culture that attempts to generate public spaces that strengthen social participation and the state's role as a regulator relies on the strengthening of transparency.

Thus, the role of the society grows as the private sector embeds itself in the role of the state, as the coverage of services still depends on the government. On the other hand, the participants mention the difficulties faced by the society in participating, as "*management control requires the implementation and training of inspectors and managers*." In this sense, the implementation of qualitative indicators of permanent education actions in state-level hospitals managed by SHOs might contribute to shared management, service, and the involvement of the society, as an act of citizenship.

Therefore, discussing the opinions of major social players also means collaborating with the feasibility of management tools that go beyond the health sector and are adopted in everyday life, given that social processes are interconnected, and that the formation of a good health system relies on the defense of a state of social protection. It is therefore possible to identify in the responses the lack of resources to acknowledge local practices that contribute to the state's regulation of the SHO model.

5. Conclusion

The opinions of administrators and counselors on the SHO management model have contributed to amplifying the perception of elements that they point to as improvements in the state's role as a regulator. The fragilities and potentialities indicated in the study aim to update and address new elements under the management of hospital units by the private sector, attempting to contribute to the quality of access to health services.

In this manner, and evoking permanent education in health, we suggest that new studies be done to advance the training and technical qualifications on the state's role as a regulator in the relations with the private sector.

Including the vision of administrators, who are usually chosen politically, adds new elements to the discussion on the effects of private participation in public administration, transcending the theoretical debate and including in the discussion aspects related to practice. In this sense, we hope the study helps to perfect the available administration models. For this purpose, it is necessary to create public spaces of debate on the role of the state in legislative and executive regulation and of social participation.

Declaration of interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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